



Base Hospital Contact: Required for vaginal bleeding at > 20 weeks pregnancy and newborn delivery ① ② ③ ④

1. Do not delay transport for treatment if suspected eclampsia; Manage delivery en route
2. Assess airway and initiate basic and/or advanced airway maneuvers per (MCG 1302)
3. Administer **Oxygen** per (MCG 1302)
4. Establish vascular access (MCG 1375)
Vascular access should not take precedence over controlled delivery or emergency transport
5. For poor perfusion:
Normal Saline 20mL/kg IV/IO rapid infusion per MCG 1309
CONTACT BASE for persistent poor perfusion to obtain order for additional **Normal Saline 20mL/kg IV/IO** per MCG 1309
6. If crown is showing with amniotic sac intact, pinch sac and twist the membrane to rupture

BREECH DELIVERY

7. Support presenting part and allow newborn to deliver
8. If head does not deliver, place gloved hand inside mother and form "V" formed with fingers by baby's face to provide an opening for the airway

PROLAPSED CORD

9. Position mother face down and hips elevated
10. Check cord for pulses
11. If no cord pulsation, manually displace presenting fetal part off the umbilical cord until pulsations are felt; maintain elevation of the presenting part until transfer of care
12. Wrap cord with moist gauze

NUCHAL CORD

13. If nuchal cord is loose attempt slipping the cord over the head prior to delivery
14. If the cord is too tight to easily slip over the head, clamp the cord in two places 1 inch apart and cut the cord with scissors



Treatment Protocol: PREGNANCY COMPLICATION

Ref. No. 1217-P

SHOULDER DYSTOCIA

15. Perform McRobert's maneuver in order to deliver the anterior shoulder ④

MATERNAL HYPERTENSION (BP \geq 140/90mmHg) / ECLAMPSIA ⑤

16. Place mother in left lateral decubitus position
17. For seizure, treat in conjunction with [TP 1231-P, Seizure](#)





SPECIAL CONSIDERATIONS

- ❶ Pediatric patients who are pregnant must be evaluated for child maltreatment and are at high risk for complications during delivery for the mother and the newborn.
- ❷ This protocol was intended for complications of pregnancy at the time of delivery; if patient is known to be pregnant and has complaints not associated with labor or delivery treat per [TP 1202-P, General Medical](#) or most applicable protocol.
- ❸ If the patient has vaginal bleeding associated with known pregnancy >20 weeks, Contact Base and communicate signs and symptoms so that the receiving hospital can pre-notify OB consultants as needed.
- ❹ Any delivery after the first trimester (12 weeks) should be considered childbirth for the purposes of this treatment protocol and paramedics should contact Base to discuss the management and transport. In general, delivery prior to 20 weeks gestation is nonviable and does not require resuscitation. However, dates can be incorrectly estimated, therefore, Base Contact is strongly encouraged. Any *potentially viable birth* should be resuscitated in the field and transported to a perinatal center that is also an EDAP (with a NICU if <34 weeks gestation). Births prior to 20 weeks do not necessarily require specialty center care and can be transported to the MAR.
- ❺ Shoulder dystocia is inability to deliver the anterior shoulder, which usually occurs in large newborns. If delivery fails to progress after head delivers, hyperflex mother's hips tightly in knee to chest position and apply firm suprapubic pressure in attempt to dislodge anterior shoulder (McRobert's maneuver).
- ❻ Hypertension in a pregnant or recently post-partum is a sign of eclampsia, which required immediate emergency and obstetric care. Additional signs of eclampsia are edema and seizures. Patients who are ≥ 20 weeks pregnant or ≤ 6 weeks post-partum with hypertension (BP $\geq 140/90$ mmHg should be transported to a Perinatal Center for evaluation.